



## RHODE ISLAND MEDICAL ASSISTANCE PROGRAM DEPARTMENT OF HUMAN SERVICES ENHANCED PRIOR AUTHORIZATION PROGRAM

Use	Drugs covered	Relevant Diagnosis / Physical Status	Approval Criteria or Documentation required
Web PA Form	under Prior Authorization		
PA14	ANTIHISTAMINES – Rx 2 <sup>ND</sup> GENERATION	N/A	EVIDENCE OF THERAPEUTIC TRIAL AND FAILURE WITH OTC LORATIDINE PRODUCTS, OR     DOCUMENTED ADE TO OTC LORATIDINE PRODUCTS
PA09	Вотох	SPASTICITY	EVIDENCE OF RELEVANT DIAGNOSIS
PA02	CNS STIMULATORS	Narcolepsy Depressive Disorder Major Depressive Disorder Major Depressive Affective Disorder ADD-Attention Deficit Disorder ADHD-Attention Deficit Hyperactivity Disorder	EVIDENCE OF RELEVANT DIAGNOSIS
PA08	Cox 2 Inhibitors:	FAMILIAL ADENOMATOUS POLYPOSIS	FAMILIAL ADENOMATOUS POLYPOSIS - Celecoxib Only
	* PATIENTS WITH PRESCRIPTIONS FOR ROFECOXIB 50MG PER DAY FOR GREATER THAN 5 DAYS WILL BE DENIED	RHEUMATOID ARTHRITIS  OSTEOARTHRITIS  ACUTE PAIN  CHRONIC PAIN	RHEUMATOID ARTHRITIS - Presence of at least one GI toxicity risk factor present or Documented Therapeutic Failure of 1 nonselective NSAID Age ≥ 75 years of age Prior history of GI Event Concurrent use NSAIDS and corticosteroids Concurrent use NSAIDS and oral anticoagulants  OSTEOARTHRITIS - Presence of at least one GI toxicity risk factor or documented therapeutic failure of one nonselective NSAID or APAP Age ≥ 75 years of age Prior history of GI Event Concurrent use NSAIDS and corticosteroids Concurrent use NSAIDS and oral anticoagulants  ACUTE PAIN - Presence of at least 1 GI toxicity risk factor Prior history of GI Event Concurrent use NSAIDS and corticosteroids Concurrent use NSAIDS and oral anticoagulants  CHRONIC PAIN - Presence of at least one GI toxicity risk factor Prior history of GI Event Concurrent use NSAIDS and corticosteroids
PA03	ERECTILE DYSFUNCTION	ERECTILE DYSFUNCTION IMPOTENCE OF ORGANIC ORIGIN	MALES ONLY EVIDENCE OF RELEVANT DIAGNOSIS DOCUMENT UNSUCCESSFUL PRIOR TREATMENTS
PA05	FOLLICLE STIMULATING HORMONE	Hypogonadism	MALES ONLY EVIDENCE OF RELEVANT DIAGNOSIS
PA11	FUZEON	HIV	APPROVAL LIMITED TO INFECTIOUS DISEASE SPECIALISTS PERSISTENT VEREMIA WITH CURRENT THERAPY CURRENTLY PRESCRIBED 3 ANTIRETROVIRALS FAILED > 6 DIFFERENT ANTIRETROVIRAL DRUG THERAPIES (EQUIVALENT TO TWO COURSES OF TREATMENT)
PA06	GROWTH HORMONES	GH DEFICIENCY — ADULT ONSET GHD AS A RESULT OF INJURY PREVIOUS CHILDHOOD GROWTH HORMONE DEFICIENCIES REQUIRING CONTINUOUS TREATMENT INTO ADULTHOOD	APPROVAL LIMITED TO ENDOCRINOLOGISTS  DIAGNOSTIC TEST RESULTS:  Insulin tolerance test with growth hormone (GH) levels < 5ng/ml or  Arginine stimulation test with GH levels < 5ng/ml (or < 9ng if arginine combined with GH-releasing hormone or  An equivalent diagnosis test

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## **Rhode Island Medical Assistance Prior Authorization Program**

Use	Drugs covered	Relevant Diagnosis / Physical Status	Approval Criteria or Documentation required
Web PA	under Prior Authorization		
Form PA13	LONG ACTING	CANCER	EVIDENCE OF APPROPRIATE DIAGNOSIS, OR EVIDENCE OF ONE OF THE
	NARCOTICS	CHRONIC NON-MALIGNANT PAIN	FOLLOWING DRUG THERAPIES:
			Antineoplastic Agents dispensed in the past 12 months, or
		NEUROPATHY	<ul> <li>Opiate and non-Opiate analgesic agents totaling 60 days of drug supply, or more, in the last 90-days, or</li> </ul>
			C-II and C-III opiate-combination drug products with
			acetaminophen or ibuprofen in which average daily doses exceed
			the following ceiling dosage limits:
			<ul> <li>Acetaminophen Combination products – Exceeding 4,000mg per day.</li> </ul>
			<ul> <li>Ibuprofen Combination products – Exceeding 3,200mg</li> </ul>
			per day
			Or, C-II and C-III opiate-combination drug products totaling 30- days of drug guaphy or more in the last 30 days.
			days of drug supply, or more, in the last 30 days.
PA01	MODAFINAL	NARCOLEPSY	Evidence of relevant diagnosis
		DEPRESSION PARKINSONISM	
		CENTRAL SLEEP APNEA	
PA15	<b>O</b> PHTHALMIC	MS INDUCED FATIGUE N/A	EVIDENCE OF THERAPEUTIC TRIAL AND FAILURE WITH PREFERRED
PAIS	ALLERY	N/A	OPHTHALMIC ALLERGY AGENTS, OR
	MEDICATIONS - RX		DOCUMENTED ADE TO PREFERRED OPHTHALMIC AGENTS, OR
			GLAUCOMA DIAGNOSIS:
			<ul> <li>Direct, ICD-9 diagnosis, or</li> <li>Inferred diagnosis through evidence of ophthalmic anti-</li> </ul>
			Glaucoma agents.
PA07	PROTON PUMP INHIBITORS	HYPERSECRETORY CONDITIONS GASTROESOPHAGEAL - GERD	EVIDENCE OF RELEVANT DIAGNOSIS
	INHIBITORS	REFLUX DISEASE	
		CYSTIC FIBROSIS	
		RHEUMATOID ARTHRITIS	
PA07	PROTON PUMP INHIBITORS	HISTORY OF GI COMPLICATION	HISTORY OF GI COMPLICATION  GI Bleed Hemorrhage Perforation
	I I I I I I I I I I I I I I I I I I I	PEPTIC ULCER DISEASE - PUD	PEPTIC ULCER DISEASE (PUD)
			Must be within last 3 months Tested for H.Pylori and treated for H.Pylori
		NSAID FAILURE	NSAID THERAPY WITH GI TOXICITY RISK FACTORS
			Presence of at least one GI toxicity risk factor or Documented
			Therapeutic Failure of One nonselective NSAID or APAP ≥ 75 years of age
			History PUD or GI Bleed Diagnosis, Rheumatoid Arthritis
			Concurrent high dose NSAID use
			Concurrent warfarin or steroid use
		GASTRITIS	GASTRITIS  December 2 discussion part 6 months plus
			Document 2 diagnosis in past 6 months plus  Document prior trial prescription or OTC H2 receptor antagonist
		Posterior Laryngitis	POSTERIOR LARYNGITIS - Omeprazole Only
PA10	Tracleer/Flolan/	PRIMARY PULMONARY HYPERTENSION	APPROVAL LIMITED TO CARDIOLOGISTS AND PULMONOLOGISTS
	Remodulin	SECONDARY PULMONARY HYPERTENSION WITH A CONNECTIVE TISSUE DISORDER	FUNCTIONAL WHO CLASS OF I, II, III, OR IV
PA04	WEIGHT LOSS /	BMI > 30kg/m <sup>2</sup> or	INITIAL COVERAGE:
	ANTI-OBESITY	BMI 27-30 kg/m <sup>2</sup> And 2 risk factors	Patient meets approval criteria. Approval will be for 3 months.
		DIABETES MELLITUS	MONTH 3-6 COVERAGE:
		Hypertension Hyperlipidemia	Patient has weight lost of 4 lbs by first month and maintained or exceed this loss in month 2 and 3. Approval will be for additional 3 months.
			Month 7-12 coverage:
			Patient weighs less than or equal to the weight at the 3-month time period. Approval will be for an additional 6 months.
			MONTHS BEYOND 12 MONTHS:
			Requires 6 months break in therapy after which initial criteria begins

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## **Rhode Island Medical Assistance Prior Authorization Program**

Use Web PA Form	Drugs covered under Prior Authorization	Relevant Diagnosis / Physical Status	Approval Criteria or Documentation required
PA12	XOLAIR	АЅТНМА	APPROVAL LIMITED TO PULMONOLOGISTS, ALLERGISTS, AND IMMUNOLOGISTS AEROALLERGEN PRESENCE IGE > 30 IU/ML INADEQUATELY CONTROLLED ASTHMA ON ORAL/INHALED MEDICATIONS

Criteria and forms for submission of patient information for prior authorization approval are available at the DHS Medicaid Website: <a href="https://www.dhs.ri.gov/dhs/heacre/provsvcs/mpharpa.htm">www.dhs.ri.gov/dhs/heacre/provsvcs/mpharpa.htm</a>

## Current drugs requiring Prior Authorization and Pa request Form.

PA01	Modafinal
PA02	CNS STIMULATORS
PA03	ERECTILE DYSFUNCTION
PA04	WEIGHT LOSS / ANTI-OBESITY
PA05	FOLLICLE STIMULATING HORMONE
PA06	GROWTH HORMONES
PA07	PROTON PUMP INHIBITORS
PA08	Cox 2 Inhibitors
PA09	Вотох
PA10	Tracleer/Flolan/Remodulin
PA11	Fuzeon
PA12	Xolair
PA13	LONG ACTING NARCOTICS
PA14	Antihistamines – Rx 2 <sup>nd</sup> Generation
PA15	OPHTHALMIC ALLERGY MEDICATIONS - RX

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